AN ASSESSMENT

OF

PUBLIC–PRIVATE PARTNERSHIP OPPORTUNITIES

IN

INDIA

EXECUTIVE SUMMARY

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November 2004

Submitted by:
LTG Associates, Inc.
Social & Scientific Systems, Inc.

Submitted to:
The United States Agency for International Development/India
Under USAID Contract No. HRN–C–00–00–00007–00

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An Assessment of Public–Private Partnership Opportunities in India was made possible through support provided by the United States Agency for International Development (USAID)/India under the terms of Contract Number HRN–C–00–00–00007–00, POPTECH Assignment Number 2004–207. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

ACRONYMS

ANM	Auxiliary nurse–midwife
AP	Andhra Pradesh
APSMP	Andhra Pradesh Social Marketing Programme
BCC	Behavior change communication
CBD	Community-based distribution
CFW	Commissioner of Family Welfare
CMS	Commercial Market Strategies Project
CYP	Couple year of protection
DFID	Department for International Development (United Kingdom)
DHFW	Department of Health and Family Welfare
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HLL	Hindustan Latex, Limited
IEC	Information, education, and communication
IFPS	Innovations in Family Planning Services project
IUD	Intrauterine device
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MHFW	Ministry of Health and Family Welfare
MOU	Memorandum of understanding
NGO	Nongovernmental organization
ORS	Oral rehydration salts
PHC	Primary health center
PPP	Public–private partnerships
PSI	Population Services International
RCH	Reproductive and child health
RH	Reproductive health
SEWA Rural	Society for Education, Welfare, and Action Rural Project (Gujarat)
SHRC	State Health Research Committee
SIFPSA	State Innovations in Family Planning Services Project Agency
UP	Uttar Pradesh
USAID	United States Agency for International Development
USHC	Urban slum health center
VCT	Voluntary counseling and testing

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EXECUTIVE SUMMARY

In the fall of 2004, the United States Agency for International Development in India (USAID/India) commissioned a four-person team to review public–private partnerships (PPPs) focused on health in India and to provide suggestions for future activity. The Mission was specifically interested in partnership structures that might be appropriate for implementation under the pending task order for the private sector program.

The team met with USAID/India and its primary implementing partner, the State Innovations in Family Planning Services Project Agency (SIFPSA). The team then divided and conducted field visits throughout India, including Uttar Pradesh, Bihar, Chhattisgarh, Gujarat, Andhra Pradesh, Karnataka, and Tamil Nadu. Interviews were also conducted with various donor organizations and individuals familiar with PPPs in India. In all, the team examined and assessed nearly two dozen PPP models.

Of the seven major PPP models reviewed, five are suggested for further consideration by USAID and SIFPSA:

- clinical contraception through private providers,
- urban slum health centers,
- contracting out rural primary health care centers,
- social marketing, and
- obstetric and pediatric emergency services.

CLINICAL CONTRACEPTION THROUGH PRIVATE PROVIDERS

Such a model would involve a contracting out partnership between the Uttar Pradesh Department of Health and Family Welfare (DHFW) and private hospitals and nursing homes. The private hospitals and nursing homes would provide sterilization and intrauterine device (IUD) services to the rural poor, including transportation to and from the hospital, and would be reimbursed for the costs by the DHFW. Three changes are suggested.

- The private hospitals and nursing homes should either be reimbursed for their total costs or paid a flat fee for services (1,000 rupees [Rs] for voluntary sterilization and Rs100 for IUD).

- There should be no restrictions regarding age or parity.

- The model should be tested in two or three districts before being replicated throughout the state.

URBAN SLUM HEALTH CENTERS

Such a model would involve a contracting out partnership between the Uttar Pradesh DHFW and qualified nongovernmental organizations (NGOs), built on the successful model in Andhra Pradesh. The government would build urban health centers in slum areas

to serve the poor. The centers would be fully equipped by the government. The NGOs would pay no more than one third of the costs; the government would pay the rest. The NGOs would hire their own staffs and provide all needed primary health services, including outreach. A local advisory board would represent the communities in the catchment area. Two modifications are recommended:

- the government should pay 100 percent of the costs (or a large enough fixed payment to cover all costs), and

- the urban health centers should hire specialists under contract on an as-needed basis (user fees would cover these costs).

This model should also be tested before being fully expanded throughout the state.

CONTRACTING OF RURAL PRIMARY HEALTH CARE CENTERS

Such a model would also involve a contracting out partnership between the DHFW and qualified NGOs, as above. SIFPSA has tried to set up a similar type of partnership without success. It seems worth trying again, perhaps in another district where there are defunct primary health centers. The following three modifications are suggested:

- payment of 100 percent of the costs, establishment of an advisory board, and full primary health care services, including outreach, as above;

- development of the center as a model for the area, including the training of government primary health care personnel in how to operate a successful primary health center; and

- addition of an emergency ambulance service.

SOCIAL MARKETING

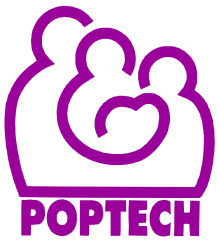
Such a model would involve a contractual relationship between SIFPSA or the DHFW and one or more social marketing organizations. The characteristics of the final social marketing model would be determined after a comprehensive review of current social marketing experience, both within India and throughout the world. The review would consider program costs, alternative mechanisms for achieving similar objectives, consumer characteristics, the current programming environment, and other relevant factors.

OBSTETRIC AND PEDIATRIC EMERGENCY SERVICES

Such a model would involve a contracting out partnership between the DHFW and qualified NGOs, similar to the SEARCH model in Tamil Nadu. The government would loan an ambulance to the NGO, which would be responsible for all operating costs (such as fuel, maintenance, and driver), and which could charge Rs5 per km for its use (persons below the poverty level would be exempt). The ambulance could be used for any emergency to transfer patients to the nearest hospital. This partnership should be tried in several rural and remote areas.

In addition to the above models, there are several models that have potential but may be more difficult to replicate and expand. (These are outlined in section IV, Other Models, Proposals, and Suggestions.)

Comments are also provided on management and policy issues that have an impact on the models reviewed. The PPPs that are achieving success in India are doing so despite numerous challenges and obstacles. Principal among these are management structures and conventions that have been designed for a large, centralized public heath authority and that rarely have the flexibility to meet the needs of a specific community, partner, or intervention.



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